Department of Labor and Industries

This form must be completed by a vocational Rehabilitation counselor who has received a referral from a self-insured employer.

****** Counselor is responsible for sending a copy of this form to each vendor ******

RESET

SELF INSURANCE

RETURN TO WORK PLAN TIME ENCUMBRANCE

☐ **Original** ☐ **Modification**

		Date of this request	Claim number
Vocational counselor or Intern	VRC or Intern ID #		
Vocational counseling firm's name	Phone number	Injured worker's name	Date of injury
Address	Firm Provider # & branch	Home address	Phone number
City/State	ZIP+4	City/State	ZIP

Type of Modification	**Plan Dates Requested**
☐ Change in time frames	☐ Effective start date _____
☐ Change in goal	☐ Change start date to _____
☐ Change in training site	☐ Interrupt plan on _____
☐ Change in costs	☐ Restart plan on _____
	☐ Continue time loss to _____
☐ Other (specify)	☐ LEP to start on _____
_____	☐ LEP to end on _____
	☐ End date, 1st 52 weeks _____
	☐ Early plan termination _____

Goal		DOT #	
Method	Training site	Contact person	Phone
Date signed	Signature, Assigned Vocational Counselor. X		

Company	Phone No.	FAX No.
Assigned Vocational Counselor	Date	Signature

Employer or Service Representative ☐ Approved ☐ Not Approved	Date signed	Phone No.	Signature